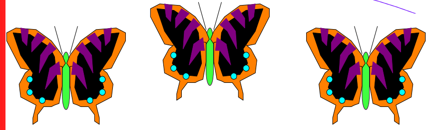

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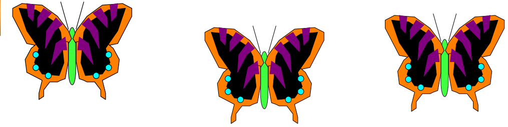
ODC NEWS & VIEWS

SEPTEMBER 2009



HAPPY BELATED BIRTHDAY TO A WOUNDERFUL PHYSICAINS' ASSISTANT RICK H

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Do You Know Michelle in Elgin?

Name: Michelle Villar

Title: Bilingual Case Manager

How long have you been with ODC? I Started August 07, 2000 this will make it 9 years.

What types of things do you do with ODC? Describe your family (define family however you want)? I'm a Bilingual Case Manager RW/DRS Case Manager and I help clients with Primary Care, Case management, Support Services ,Dental, Medication Adherence and monthly Educational Luncheons and ODC Bingo and anything else that I can do to make my clients lives a little easier everyday. I love what I do as a Case Manager and feel very privileged everyday to be parts of every single one of my client's lives. It's very rewarding to me. My immediate family all lives here in South Elgin, Illinois and my father and other half of family lives in Spain.

What do you enjoy doing in your free time? I enjoy time with my family, gardening, crocheting and spending time with close friends and pampering myself.

Where is the farthest place from home you have ever been? The farthest place is Spain

What is your favorite food? My favorite food is Mexican food

What one thing do you want to do that you haven't done yet? One thing that I have not done and would love to do is travel to different countries with my family and learn about all the cultures

Who is the most impactful person in your life or most impactful person on humanity (dead or alive)? The most impactful person was Jeannie White, Ryan White's Mother. Just learning about all the struggles and stories that she shared was so powerful to me.

LOOK FOR THE SUGGESTION BOX IN EACH CLINIC AND PUT YOU COMMENTS, CONCERNS AND SUGGESTIONS IN IT AND THEY WILL BE ADDRESSED

***AIDS Run & Walk Chicago* 2009 will be held on Saturday, October 3 in Grant Park! This is a chance for the clients to give back to Open Door Clinic so let's all get together and walk for the clinics and ourselves. I have participated in the past and it is a lot of fun and a great time. There are so many things to see and the entertainment is great and you meet a lot of fantastic people. So please contact your case managers and tell them that you want to walk/run this year and we can get a team of clients together and go……**

Support Groups

1 - Ernie from Gilead
2- Shirley have a great time
3 - Mike listing to Ernie
4- Ernie teaching
5- Mary H. even learning

Did you know that the Aurora and Elgin Clinics are currently hosting support groups for there clients every month, they have hosted these groups for many years now. Mary H., Marcos B. and Michelle V. hosts these groups to help the clients deal with day to day issues, social and educational topics. From what I have heard from the clients that are and have attended these groups, they have a good time socializing and learning from the speakers that come and talk to the clients. Everyone usually learn something from the conversations that are held.

Mary host the Aurora Support Group twice a month. There are times that a guest speaker comes and talks and dinner is provided . Other times it is just a social gathering. At the social gatherings dinner is provided or the clients decide to have a pot luck dinner.

Marcos B host the Elgin Latino support group once a month and also has different things going on like speakers and outings.

Michelle V. host the BINGO group in Elgin once a month. This group is a time to socialize with other clients and a chance to have a good time and win some cool prizes.

So it is time to take some time out for yourself and come to one or all of the support groups and do something for yourself.

If you want more information these support groups give your case manager or the ODC staff that host that support group a call and they will help you.

HIV/AIDS Presents "Opportunity" for Social Change, UNAIDS Chief Sidibe Says

April 10, 2009

Although HIV/AIDS poses significant challenges, the disease also presents opportunities for social change, UNAIDS Executive Director Michel Sidibe said recently during a visit to Senegal, AFP/Google.com reports. Sidibe said people should not regard HIV/AIDS simply as a problem but rather should use HIV/AIDS as an "entry point" to discuss social issues and "bring about changes in legislation." According to Sidibe, HIV/AIDS presents a "political opportunity to trigger profound changes in society, to talk about difficult issues like sex education, homophobia and human rights issues in general, like the position of women in society." He added that he regards UNAIDS "as a political agent which has to demand change" rather than as an organization with "clearly outlined programs." He said, "UNAIDS has to be the voice for the voiceless, it should have political courage."

In addition to presenting opportunities for social changes, HIV/AIDS garners financial resources that could contribute to improvements in local health care systems, AFP/Google.com reports. According to Sidibe, of the $25 billion needed to fund universal access to HIV/AIDS treatment, $9 billion is "earmarked for overhauling health care systems." He said that stakeholders should "make sure" that such funding is not used exclusively for HIV/AIDS programs, adding that these resources "could be a way to transform and rebuild society around the social needs of the population."

Sidibe also discussed efforts to secure additional financial resources for the Global Fund To Fight AIDS, Tuberculosis and Malaria, which currently is seeking $4 billion for the period between 2008 and 2010. According to Sidibe, stakeholders "need to continue to mobilize resources and redouble our efforts to make sure the Global Fund is totally financed." However, rather than pressure international donors to contribute funding during the economic downturn, UNAIDS should consider how to optimize partnerships, Sidibe said. He added that the agency should "make sure that we can demand a certain performance, with an accountability and obligation to produce results" in addressing HIV/AIDS. Sidibe said, "Universal access to care, treatment and prevention is my number one priority," adding that "money is essential" to achieve this goal.

Dot Com Dating

By Louis Hobson & Bryan Gooding

In the next few issues we will present a series of articles with the hope of helping to inform POZ people who may need a little help when trying to navigate the dating world in the new millennium. We will tell you about different sites as well as some tips for navigating them. These reviews are meant to inform not indorse or criticize.

Poz.com.

This site is run by POZ Magazine. Gay, Straight, Lesbian, Trans gender friendly. You can reach the personals through the community link on there site or go directly to personal page at personals Poz.com. There are currently 82,000 members nationwide. You can create a profile; upload pictures (G only). Generally profiles with pictures get more responses. Search for others in your area or across country. You can contact others and they can contact you by leaving message (s) on (the) site. An email will be sent to you informing you that you have mail waiting. From there you can choose to exchange email addresses.

You can blog, and join various forums; find the latest drug and treatment information. There is access to "Poz Mentor" an online support group for people in all stages of HIV.

There is no cost to access this site .It can be a great place for dating, making friends, or seeking information.

Pozsingles.com

This site is geared towards people living HIV, Hepatitis, Herpes or other STD's. Basic membership is free but there is a charge to get to the good stuff.

With basic membership you can create a profile, upload pictures, do basic searches. You can't send messages, but other members can send you messages which you can reply to. Again profiles with pictures get most hits especially if you're waiting for some one to message you. Access to blogs , forums or information is limited with out paid account.

In a paid membership you can access all blogs forums ,and information, leave and receive messages , utilize advanced search options.

Rates are as follows
$95.95 for six months
$59.95 for three months
$29.95 for one month.

While surfing the net for friendship, love or whatever, remember to be honest , keep your expectations realistic, and have fun!! Happy Surfing!!!

HIV's Silent Dangers Make Early HIV Treatment Critical, Expert Says

There's nothing like hearing the results of studies directly from those who actually conducted the research. In this summary, you'll hear Wafaa El-Sadr, M.D., M.P.H., discuss her plenary paper. It is followed by questions from reporters and comments by Julio Montaner, M.D., president of the International AIDS Society.

Wafaa El-Sadr: I spoke this morning on HIV inflammation, and the subtitle of my talk was, "A Paradigm Shift." Largely I was talking about a couple of things. What should be our goal in managing people with HIV? And ultimately, our goal is that people with HIV would have similar survival to people without HIV. They would live just as long, and they would live just as well as people without HIV.

How can we achieve this? I think we've made tremendous progress by using antiretroviral therapy in dramatically decreasing morbidity and mortality. However, we may have also missed the boat in some areas. We have assumed that after somebody's infected that they have many, many years of what's called clinical latency -- many, many years when they're infected but they're actually doing well, or they appear to be doing well. It's only when they become sick, or they've advanced a bit with HIV, or advanced HIV, that then we start thinking of what other treatments we should provide them.

There are data now that seem to suggest that during that long period when the person appears to be quite well, there are ongoing processes in their bodies, due to HIV itself, due to the virus, that may be causing some damage, some unseen damage that may ultimately have a very large impact on a person's survival, and a person's wellness.

I think the goal is to try to think about how can we use the interventions we have. Can we use antiretroviral therapy, for example, to try to dampen some of this damage that's ongoing? We don't know if that's going to be effective or not. We need to study it. We need to invest in more studies that can answer that question definitively. Because getting it right is very important: really figuring out *when* to use antiretroviral therapy. How early should we use it in HIV disease has major implications. We need to know the benefits. We need to know the risks. Because we can't take a chance on that answer, because it has implications for millions and millions of people who will start therapy based on our guidance.

The second issue is that -- so there's one gap, largely in developed countries, which is the gap between people with HIV in survival, and those without HIV. Then there's another gap, obviously, between people with HIV in rich countries and in poor countries. Clearly, there's the gap of providing access to treatment and other interventions for people with HIV -- not just antiretroviral therapy.

In poor countries, we still have a long ways to go. Only about a third are getting access. We have a ways to go. And even people who get access to treatment are not doing as well as we want them to do. They're starting treatment very late. Also, even when they start antiretroviral therapy, they seem to be at very high risk of what we call early mortality. So we have a lot of questions we need to answer. We don't have all the answers yet.

I think the message is that some people are under a mistaken impression that we've solved AIDS, that we've solved HIV, that now we know how to treat it, we can get it out there, and all the answers are there. I believe there are lots of answers at the genetic level, at the research level, as well as the implementation level. And we have to continue to push the science and push the implementation and push the practice, based on evidence.

Reporter #1: I'm Natasha Bolognesi, and I'm reporting for the Canadian Network - Education. My question is: How does your concept of starting ARV treatment earlier during the clinical latency period compare with studies which suggest that some ARV drugs actually may contribute to comorbities, such as cardiovascular disease, for example?

Wafaa El-Sadr: I think we don't know the answer to the question. I am advocating -- based on what we know from the studies available to us --that it appears that there may be definite benefits to earlier initiation of ART. But there also are likely, as well, definite risks. Clearly, there will need to be studies to be done that further our understanding of how do we balance the metaphysic risks. And especially in the health care group of individuals; in such a population you want to really make sure that the benefits outweigh the risks. Because if you're going to treat huge populations early, you want to know that most people will gain the benefits, rather than the risks.

In a more advanced population with HIV, you clearly are then willing to bear more of the risks to get the benefits. So I think it's weighing the risks and benefits that's a very complex balance.

I do believe that there are very intriguing, interesting data that suggest that earlier treatment could be advantageous. By earlier, I'm talking about above 350. I'm not talking about that people who should be getting treatment today are not getting it. In those populations I believe that the question should be studied, needs to be studied, and studied quickly. And investment should be made to make sure that these studies are done and done appropriately, and all the measurements are done within those studies.

I have to, though, caution that the vast majority people in the world are not getting access to treatment, even at the current thresholds. And that should be our focus -- to get people on treatment at the current threshold.

So I think that pathogenesis, these mechanisms, guide us to pushing harder to try to answer the questions and also to think about how are we going to answer the questions? What are we going to look for, exactly, in those studies?

I do think that the momentum is there, and the rationale is there, and we have to keep pushing to get them, to get these studies done.

Reporter #2: Hi. I'm Adam Graham-Silverman, also from the U.S.A. Dr. El-Sadr, you talked about this chronic inflammation idea as a paradigm shift. But given what you and others have just said about how far things need to go just to get treatment to those who need it at the current paradigm, I'm wondering what else, what other kind of shift might this model entail, particularly for the health systems more broadly, other options for treatment. You know, if this does become the model, what other avenues will get opened up for new ways to look at treatment prevention, care and so forth?

Wafaa El-Sadr: If I understand your question correctly, I think that there is recognition of the importance of these kinds of coagulation and inflammatory markers. And the question is: what can we do about it? Is it antiretroviral therapy that's the answer? The only answer? Or is it antiretroviral therapy and something else? Can we use agents, drugs, that have effect against inflammation, for example? That may have a benefit. We don't know that, in people with HIV.

I mentioned the very large study that was done in people without HIV, that did show that using the statins -- those are drugs that are anti-cholesterol drugs that appear to have remarkable impact in the general population. We don't know what impact that might have in HIV-infected individuals. I think it opens new avenues for trying to think about not only antiretroviral therapy, but also other potential possibilities, and other interventions, as well.

I think people should really be creative and look at what's on the shelf, and what's been used before

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HIV's Silent Dangers Make Early HIV Treatment Critical, Expert Says

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and discarded and maybe really try to go outside the box of thinking of other drugs that we haven't thought of as anti-HIV drugs. I'm not sure that they work by themselves, but they might work as adjunctive -- if they demonstrate a benefit - and can adjunctively be used with antiretroviral therapy, potentially.

Reporter #3: Are there drugs and their broader public health interventions that may also be worth looking to?

Wafaa El-Sadr: Again, same issue. The whole issue of inflammation has also possibly potentially, aiding HIV transmission, HIV acquisition. We know that, for example, having herpes infection or genital ulcers appears to make you more vulnerable to getting HIV. And treating another infection and suppressing inflammation potentially could help in that way. Although more studies have not demonstrated a benefit from such treatment, in large clinical trials.

I guess, going back to the issue of early treatment: there are two ways of thinking about early treatment. You have to think about the benefits to the individual with HIV who is getting treated. And then you have to think about the prevention benefits and that's the balance.

If, for example, we discovered that it's not really of benefit to treat people very early on for their own health, but it does help in prevention; would that be the way to go? It's an interesting question.

Julio Montaner: I consider that my invitation to the microphone. I'm Julio Montaner, and I've been working on these things for a little bit. [Dr. Montaner is President of the International AIDS Society and Clinical Director, British Columbia Centre for Excellence in HIV/AIDS] This panel has been wonderful in outlining some of the major issues. I want to give credit to Wafaa. Wafaa is extremely humble. She's been very, very careful in how she's describing the results of her studies. The SMART study was a wonderful piece of work that really taught us tremendous new information that has dramatically changed the way we approach -- I approach -- HIV treatment in the clinic.

This is the problem. The problem is that it has moved the goalpost so far out there for antiretroviral therapy that when we come here to Cape Town, and Paula is reminding us that all of this is irrelevant to her and 90% of the people in the world because there is no money, she's totally right.

So we're here to highlight the fact that the goals that were stated for the universal access in 2001 are baby goals. Because the goals today are massively greater, based on the information that is here. And the information that is here actually contains with it the solution to Paula's problem, and to the problem of the world. Because, thanks to Wafaa's interpretation of the inflammatory nature of HIV infection which, her own data shows, gets shut down and cooled off with antiretroviral therapy, the International AIDS Society-USA needed no more data to incorporate a whole host of other conditions in people with normal CD4s as individuals who are candidates for treatment

Now, that's by no means a total consensus out there. But I think the IAS-USA guidelines are fairly well respected, and are trying to push the envelope, and telling us that if you have a CD4 count over 300, with no upper limit, but you've had chronic active hepatitis of any kind, if you have cardiovascular risk, if you have so on and so forth, nephropathy from HIV, and the like, you are a candidate for antiretroviral therapy.

So, if you put the story together, and look at it from the very wholistic, comprehensive way, what I'm telling you is that the most aggressive guidelines today open the door for almost universal treatment with antiretroviral therapy. Almost. People come to the clinic today. You don't say, "Do you qualify for antiretroviral therapy?" No. What you say is, "Is there any reason why I *shouldn't* be giving you antiretroviral therapy?"

Because you brought up the issue of toxicity of treatment.

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WORD SEARCH

W E R H F C D H J M U C X C B M K U Y G F B N M K M
R P N G N T H F E S E P Y T O E R E T S H N K J O D
E R R I T H B C D D N M K O K A D F G H V H R B H N
B E A S C E M N O I T A L S I G E L D F Y T I V O L
V J H J K C L P P O I U Y T R E A W Q V B L N L O B
T U G M K J A H T G R D X C D G R T F C Z V G Y U V
I D F E R T Y V I U I O P L E K J H G E F D S A H R
I I D D B F O R M A N C E M L K J H G S V C X Z B T
A C S E R A S D I A F G E H V R D E E S S F G H N Y
S E A M F E S R Z U A S S L C D E T H E R A P I E S
F S Z O V P W E E G E T U O B D E A D N E C B H J K
V X Q G U I O P R D S L N T U A I K J T N V D F I M
C C A R H U O O B L I G A T I O N S D I R G H G O J
B V R A U H N L V C C N W E R D E O D A A C O B K G
N E Z P K T O I I E D V H B N A K O I L M V M N M D
D B W H L J O T L B G H N I B C N E E C R T O J L R
L N S I O N S I T R D V B N B E S D A S S R P K P G
I M X C J I H C G F D S A W E I T Y F U I N H J N T
U L E K T L E A R M A R K E D Z T X C O V B O N M Y
B P D A C R F L V T G B Y H N U J M I K R O B C L U
E O T Y G B C S C O M B A T S E R T G H J M I B N O
R S Y O U R F D E G J K Z S E R F V G T H J A K Y U

COMBAT
DEMOGRAPHIC
EARMARKED
ESSENTIAL
FORMANCE
HOMOPHOBIA
INHIBIT
LEGISLATION
MOBILIZE
OBLIGATION
OPTIMIZE
POLITICAL
PREJUDICES
REBUILD
SENEGAL
SPURRED
STATISTIC
STEROTYPES
THERAPIES
TRANSFORM
UNCONSCIONABLE
VACCINE

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The toxicity of *no* treatment is so much greater. And if not, ask Wafaa. Wafaa showed in the SMART study. The SMART study, *a priori*, had the preconceived hypothesis that less treatment was going to be better, because you were going to save the toxicities. And guess what? Actually it was the other way around. It was worse. Because it gave you the toxicity of the HIV for interrupting therapy. So all of those things that we blamed the drugs for; actually, a lot of that was *the virus*.

And so if you put the story together, we should be moving forward to embrace the new state of the art and recommendations. We will get the collateral benefit in prevention, controlled epidemic, decreased inflammation, but we need to be sure that we scale up from the bottom up. We cannot start giving people treatment because they have an inflammatory this and that, when we haven't really covered 100% of those with 250 CD4s. And only then, we'll move to the 300, and to the 350. This has to be hierarchically progressed. Otherwise, it's unethical. It would be wrong. And we would not accept the authority.

Craig McClure [Executive Director of the International AIDS Society]: I think it's important to add that the messaging from this conference needs to be clear that, of course, people who are sick and dying with low CD4s need to be prioritized for treatment. The problem is, those people, when they get on treatment, are dying, anyway.

They're dying of tuberculosis. They're dying of other AIDS-related conditions and non-AIDS related conditions. And the other problem is that the donor community and governments themselves in low- and middle-income countries are afraid that the money for treatment will be a bottomless pit that goes on and on and on.

So, unless we treat people that are healthier, with higher CD4 counts, we will never see an end to the expenditures that will increasingly go up, up, and up. But if we make an all-out effort to treat people earlier, treat people in a sustainable way, the epidemic will come to an end. **Reporter #4:** I've heard Julio make this argument about three times. It's very compelling and it's very rational. And so what I'm ... And I've heard all these moral statements. Stephen Lewis last night, and so forth. And it just seems like it's falling on deaf ears, up there in the international community. I don't know if Julio yelling at the G-8, if it's really going to make much difference. And so I guess I'm wondering -- maybe it's an impossible question -- but what's going to make this real outside of this meeting, this argument that we really need to *increase* funding, not just flatten it? Not just keep it the same?

Craig McClure: You have the first answer.

Julio Montaner: *You* will.

Craig McClure: Exactly.

Julio Montaner: You will. That's the reason why I'm here, and that's the reason why *you're* here. We want you to put it on the front page today, tomorrow, the day after; and call them by their names.

The reason why we're here is because -- and you hear this every press conference -- if we were here to just talk about the science, we would be doing exactly what Paula doesn't want us to do: celebrate the science and forget about the fact that the implementation gap is growing and growing and growing. And science that is not implemented is useless. So we're here to ask you for your help to make this happen. And I can give you words. You know, it's criminal negligence. I'll give you words, if you want. But you know, we need your help to make this happen. Because the prime minister of Canada came out of the G-8 meeting saying, "Oh, by the way, you know, it's really bad that we're misleading the public, and that we make promises and we don't fulfill them. We should be changing this attitude because it lowers our credibility."

I mean, how can a leader of a country have the nerve to go to a global summit, eat and dance, and have a great time, and come out and say, "You know, it's all lies, anyways. Who cares?" And the press is not picking up on it. So we need your help to tell these people we're watching; we don't like it; and through the press, you're going to lose your votes.

Craig McClure: You'll make the difference. Communities of people living with and affected by HIV that are activists will make a difference. Researchers will make a difference. Individuals in the sclerotic international organizations that exist today, individuals who care in those organizations, will make a difference, individuals in governments will make a difference. The same people who made a difference to get us where we are today, in 2000, 2001, 2000 in Durban, that led to the resources we've had up to now, today; it's the same people that will make the difference. So please, help.

Paula Akugizibwe I think, additionally, you've pointed out all the major role players. But we also need to start bridging the gap between the people in need and the people who make these decisions. I mean, the representation of people living with HIV at this conference, as in all conferences, is pretty low, compared to the other representation of different groups. Just like donors who give money to countries rarely engage directly with the people who are ultimately the beneficiaries of the money that they're giving. Or UNAIDS conducts national AIDS pending assessments, and it specifically states that the assessment doesn't take into consideration that these are the service users.

So it's this massive gap between the high level, where decisions are made and funding is granted, and the ground, where that money is meant to be used. And that gaps needs to start being bridged. And I think that can be done by everyone in this room.

Wafaa El-Sadr: I think another issue that's coming up that many of you are aware of is kind of the concept that Stephen Lewis was talking about yesterday -- that HIV is sucking away resources from other key health threats. For example, people who are saying, "Well, let's invest in health systems." Or, "Why should we be spending money on HIV? We should be spending it on child health? On child health, or other health risks."

I think, first of all, it's an erroneous assumption. We don't know. Nobody has demonstrated evidence to suggest to me that investment in HIV has negatively impacted on any other issue. I haven't seen any data to that -- or data that looks real -- that supports that claim.

But also, I think we need to think about how transformative HIV has been, in terms of the health system. I mean, having people at the table, people with HIV at the table, people in advocacy at the table, discussing health systems, is very important in shaping the health systems. There have been spillover effects influencing HIV, influencing the quality of antiviral care that we see. There has been evidence of enhanced procurement systems, enhanced laboratory systems in many countries. Keeping people alive, mothers alive, keeps children in school. Keeping people alive makes them more productive. There are data to support that from studies in Kenya, and elsewhere.

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New IDPH Client Representative - Louis

Client Rep from Open Door

Open Door Clinic's own Louis Hobson has been named Illinois Department of Health's HIV/Aids Client Representative for the Chicago Collar Counties

Louis will be using his skill, experience, and contacts, in advocating for those living with HIV/Aids in the counties surrounding Chicago. He will be active attending meetings, conventions and other forums on the local, state , and federal level.

As he has in the past Louis will once again be one of our reps to Illinois HIV/Aids Lobby Day in Springfield, as well as Aids Watch in Washington D.C.

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So I do think we have evidence. And we haven't used that evidence well enough that demonstrates the benefit -- the benefit of people with HIV, which is clear But also the benefits on the societies in which they exist, in their communities and their families. And I think that's very important to help, again, demonstrate that HIV, by itself, is well deserving, this pandemic, of the investment; but also, that there are lots of benefits that are gained, as well, that have their own measurement.

Reporter #5: I'm Sylvia Mollet from Switzerland. I'm living in Mali since a few years. I have a question for a post-exposure treatment, which wasn't directly addressed here. But we speak about money and treatment. Post-exposure treatment
is available in Mali since quite a while. It is given to embassies and their staff. So mainly the Europeans and Americans can be treated. All Malians can be treated, also, but they are not aware of that. It is available in hospitals, but people don't know it.

So I would like to know about financial resources. Is this the problem? Which is the large check behind this? This medication is available, but people are not informed. It's available, but there's no information about it. It's not like ARV or other medication. There is no marketing.

Wafaa El-Sadr: I think it's ... I think you're right. I mean, I think it's not been highlighted enough. I'm aware of some countries where. ... We support programs in some countries. I know that in Kenya, it's available for rape victims, for example. And people utilize it. People know that they go to a facility and they get a packet with antiretroviral for post-exposure prophylaxis, after sexual violence. But it's not uniformly available in many countries. And I think you're right. It should be. And I think there should be more advocacy about it's availability, and the importance of having such treatment available for those instances.

Craig McClure: Amalio, would you like the final word?

Amalio Telenti, M.D., Ph.D. [Dr. Telenti was another plenary presenter at IAS 2009]: I just want to make a comment that is important from my side, as a laboratory person. It's that we should not forget also that science is what brought, also, treatment, and that in this very difficult fight for resources, we should make sure that we don't damage science budgets. I mean, we can do as much operation on improvement, and that's critical. But behind a new generation of treatments, or simplified treatments, or, eventually, eradication or vaccine; that needs resources. And actually it's a fraction of the resources that we're spending on treating people. So we have to be attentive with also enough money in science to avoid having to give money to people, and in the future of new effective treatments in science.

Craig McClure: Thank you for that. That's a critical comment. Two years ago in Sydney at this conference, the IAS issued the Sydney Declaration, calling for 10% of all resources for HIV to be devoted for research. Because, as good as what we've got now -- what we have is very good -- but science holds out the hope for better, better, more effective treatments, a vaccine, a cure for the future. Louise? Final comments?

Louise Kuhn [Dr. Kuhn was another plenary presenter at IAS 2009. I just wanted to say, when we talk about advocating for people to get access to treatment, that's really an important thing to be advocating for. But people don't just start at 18 years of age. And really, I think, when we talk about people who are invisible in this epidemic: children are really, fundamentally invisible -- both those that are infected with HIV, and those that are affected, because their mother is HIV infected.

The children with HIV really have special needs, and really need advocates, because their needs are different to adults. And as adults, it's our responsibility to look after them. And so I just hope that in the advocacy for adult treatment, we don't forget about the children, both those that are infected and affected; and think about programs that really incorporate child health, not as a competition, but as something that's fundamental to HIV care and treatment programs.

SEPTEMBER EVENTS

- 02-Support Group (E) 5pm
- 07- Labor Day
  Clinic Closed
- 13- Education Luncheon (E)
- 11- Support Group (A) 4-6p
- 14 - Nutrition Group (E)
- 15- CAC Meeting 6pm
- 16- Gilead Lunch (E) 12p
- 20- Newsletter Deadline
- 21- Nutrition Group (A)
- 21- Staff Meeting (E)
- 24- Bingo (E)
- 25- Support Group (A) 4-6p
- 28- Nutrition Group (E)

(A) Aurora (E) Elgin

(LA) Love & Action

Dates are subject to change
Please call to verify dates

If you are interested in getting the Open Door Clinic's monthly newsletter via e-mail or have any topics that you would like to see in the newsletter.

Please email me at

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